Medicare Quality Reporting Incentive Programs Manual

Chapter 2 – The Electronic Prescribing (eRx) Incentive Program

Table of Contents
(Rev. 1, 06-11-10)

Transmittals for Chapter 2

10 - Background

(Rev. 1, Issued: 06-11-10, Effective/Implementation: 09-13-10)

Chapter 2 of this manual focuses on the requirements for the Electronic Prescribing (eRx) Incentive Program, a quality reporting incentive program which promotes the adoption and use of eRx systems. eRx is the transmission of prescription or prescription-related information through electronic media. eRx takes place between a prescriber, dispenser, pharmacy benefit manager, or health plan. It can take place directly or through an intermediary (such as a network).

Section 132 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) required the Secretary to establish a new incentive program for individual eligible professional (EPs) who are successful electronic prescribers as defined by MIPPA, beginning on January 1, 2009. While the eRx Incentive Program has similarities in structure and processes to the Physician Quality Reporting Initiative (PQRI) described in Chapter 1 of this Publication, this program is a stand alone program with distinct reporting requirements and associated incentive payment.

The eRx Incentive Program encourages significant expansion of the use of eRx by authorizing a combination of financial incentives and payment differentials. Any incentive payment earned through the eRx Incentive Program is separate from and in addition to any incentive payment that EPs may earn through the PQRI program. Except for EPs who wish to participate in the eRx Incentive Program under the group practice reporting option (GPRO) for 2010 (see §20.3), EPs do not have to participate in PQRI to participate in the eRx Incentive Program or vice-versa.

See Chapter 1, "Physician Quality Reporting Initiative," for information on the PQRI.

20 – Eligible Professionals

(Rev. 1, Issued: 06-11-10, Effective/Implementation: 09-13-10)

For purposes of the eRx Incentive Program, the definition of "eligible professional" is identical to that for the PQRI program. An EP is any one of the following:

- *Physician*
  - *Doctor of Medicine*
  - *Doctor of Osteopathy*
  - *Doctor of Podiatric Medicine*
  - *Doctor of Optometry*
  - *Doctor of Dental Surgery*
  - *Doctor of Dental Medicine*
  - *Doctor of Chiropractic*

- *Practitioner*
  - *Physician assistant*
  - *Nurse Practitioner*

- *Clinical nurse specialist*
- *Certified registered nurse anesthetist (and Anesthesiologist Assistant)*
- *Certified nurse midwife*
- *Clinical social worker*
- *Clinical psychologist*
- *Registered dietitian*
- *Nutrition professional*
- *Audiologists (as of January 1, 2009)*

- *Therapist*
  - *Physical therapist*
  - *Occupational therapist*
  - *Qualified speech-language therapist (began billing Medicare directly as of July 1, 2009)*

All Medicare-enrolled professionals in these categories are eligible to participate in the eRx Incentive Program regardless of whether the professional has signed a Medicare participation agreement to accept assignment on all claims. However, eligibility is further restricted by scope of practice to those professionals who have prescribing authority under their respective state practice laws.

20.1 – Professionals Eligible to Participate But Not Able to Participate
(Rev. 1, Issued: 06-11-10, Effective/Implementation: 09-13-10)

Some professionals who are included in the definition of "EP" above are eligible to participate but are not able to participate for one or more reasons. These include: EPs in certain settings in which Medicare Physician Fee Schedule billing is processed by Medicare fiscal intermediaries (FIs)/AB Medicare Administrative Contractors (MACs). The FI/MAC claims processing systems for the following settings currently cannot accommodate billing at the individual EP level:

- *Critical access hospitals (CAHs), method II payment, where the physician or practitioner has reassigned his or her benefits to the CAH. In this situation, the CAH bills the regular FI or Part A MAC for the covered professional services furnished by the EP.*

- *All institutional providers that bill for outpatient therapy provided by physical and occupational therapists and speech language pathologists (for example, hospital, skilled nursing facility Part B, home health agency, comprehensive outpatient rehabilitation facility, or outpatient rehabilitation facility). This does not apply to skilled nursing facilities under Part A.*

20.2 – Professionals Not Eligible to Participate in the eRx Incentive Program and Not Able to Qualify to Earn an Incentive Payment
(Rev. 1, Issued: 06-11-10, Effective/Implementation: 09-13-10)

Providers and professionals not defined as EPs are not eligible to participate in the eRx Incentive Program and do not qualify for an incentive. Services payable under or based on fee schedules or methodologies other than the PFS are not included in the eRx Incentive Program (for example, services provided in federally qualified health centers, independent diagnostic testing facilities, portable x-ray suppliers, independent laboratories, hospitals [including critical access], rural health clinics, ambulance providers, and ambulatory surgery center facilities). In addition, suppliers of durable medical equipment (DME) are not eligible for the eRx Incentive Program since DME is not based on or paid under the PFS.

20.3 – Participation by Group Practices

(Rev. 1, Issued: 06-11-10, Effective/Implementation: 09-13-10)

Prior to 2010, the eRx Incentive Program was limited to individual EPs and the determination of whether an EP is a successful electronic prescriber was made at the individual professional level, based on the National Provider Identifier (NPI). No incentive payments were available to a group practice based on a determination that the group practice, as a whole, was a successful electronic prescriber. To the extent that individual EPs (based on individuals' NPIs) are associated with more than one practice, or Taxpayer Identification Number (TIN), the determination of whether an EP is a successful electronic prescriber was made for each unique TIN/NPI combination. Therefore, the incentive payment amount was calculated for each unique TIN/NPI combination and payment was made to the holder of the applicable TIN (see §30 below).

As required by the MIPPA, beginning in 2010, group practices are eligible to qualify for an eRx incentive payment based on the determination that the group practice, as a whole, is a successful electronic prescriber. The criteria for determining whether a group practice is a successful electronic prescriber and the process for reporting by group practices under the GPRO are discussed in §60.2 below. For purposes of the eRx GPRO, "group practice" is defined as a TIN with at least 200 or more individual EPs (as identified by NPIs) who have reassigned their billing rights to the TIN.

In order to participate in the eRx Incentive Program through the GPRO, group practices must have been selected to participate in the PQRI GPRO (see Chapter 1, §20 for information on the requirements for participation in the PQRI GPRO). CMS assesses whether the participation requirements are met by each self-nominated group practice and notifies group practices of a decision.

As required by section 1848(m)(3)(C)(iii) of the Social Security Act (the Act), an individual EP who is a member of a group practice selected to participate in the eRx GPRO for a particular program year is not eligible to separately earn an eRx incentive payment as an individual EP under that same TIN (that is, for the same TIN/NPI combination) for that year. Once a group practice (TIN) is selected to participate in the GPRO for a particular program year, this is the only method of eRx Incentive Program participation available to the group and all individual NPIs who bill Medicare under the group's TIN for that program year.

30 – Payment for Reporting
(Rev. 1, Issued: 06-11-10, Effective/Implementation: 09-13-10)

A participating individual EP or group practice (see §20) who is determined to be a "successful electronic prescriber" (see §60) may earn an incentive payment with respect to covered professional services furnished by the EP (or group practice) during a specified reporting period (see §40). Section 1848(k)(3)(A) of the Act defines "covered professional services" as services for which payment is made under, or is based on, the Medicare Part B PFS and which are furnished by an EP (or group practice).

An EP who is determined to be a successful electronic prescriber for 2009 and/or 2010, may qualify to earn an incentive payment equal to 2.0% of the total estimated Medicare Part B allowed charges for covered professional services furnished by the EP during the respective reporting period. Furthermore, incentive payments for successful electronic prescribers for future years are authorized as follows:

- *percent for 2011.*
- *percent for 2012.*
- *0.5 percent for 2013.*

The eRx incentive payment amount is calculated based on an EP's (or group practice's) total estimated allowed charges for all covered professional services: (1) furnished during the applicable reporting period, (2) received into the National Claims History (NCH) file by no later than 2 months after the end of the reporting period, and (3) paid under or based upon the Medicare PFS. Because claims processing times may vary by time of the year and Medicare Carrier/AB MAC, EPs should submit claims from the end of the reporting period promptly, so that if, for example, the reporting period ends on December 31st of a particular year, claims from the end of the reporting period will reach the NCH file by February 28th of the following year. The eRx incentive payments are paid as a lump sum.

Payment for this incentive program is calculated at the individual EP level using individual NPI data and beginning in 2010, for group practices participating in the eRx GPRO, at the group practice level using TIN data. CMS uses the TIN as the billing unit so that any eRx incentive payment earned (regardless of whether the incentive payment was earned by an individual EP or a group practice) is paid to the TIN holder of record. Individual incentive payments for groups that bill under one TIN are aggregated and paid to the holder of the TIN. Some individuals (NPIs) may be associated with more than one practice or TIN, and thus CMS groups claims by TIN for purposes of the incentive. In other words, the incentive payment is made for each unique TIN/NPI combination so that an EP who qualifies for the eRx incentive payment under more than one TIN would receive a separate eRx incentive payment associated with each TIN.

Under the statute, however, there is a limitation with regard to the application of the incentive. The incentive does not apply to EPs (and group practices participating in the

eRx GPRO), for the reporting period, if the Medicare allowed charges for all covered professional services for the codes to which the eRx quality measure applies are less than 10% of the total allowed charges under Medicare Part B for all such covered professional services furnished by the EP (or group practice).

The eRx incentive payment amount is calculated using allowed charges for all covered professional services, not just those charges associated with eRx events. The term "allowed charges" refers to total charges, including the beneficiary deductible and co-payment, not just the 80% paid by Medicare or the portion covered by Medicare where Medicare is a secondary payer. Note that the amounts billed above the Medicare PFS amounts for assigned and non-assigned claims do not apply to the incentive. The statute defines eRx covered professional services as those paid under or based upon the Medicare PFS only, which includes technical components of diagnostic services and anesthesia services, as anesthesia services are considered fee schedule services though based on a unique methodology.

Other Part B services and items that may be billed by EPs but are not paid under or based upon the Medicare PFS are not included in the calculation of the eRx incentive payment amount.

In addition to the eRx incentive payment, under section 1848(a)(5)(A) of the Act, a PFS payment adjustment applies beginning in 2012 to those who are not successful electronic prescribers as defined in the 2011 Medicare PFS final rule with comment period then for 2012. The fee schedule amount for covered professional services furnished by such professionals during the year shall be less than the fee schedule amount that would otherwise apply by1.0 percent for 2012 criteria for 2013 and 2014 PFS adjustment, avoidance thereof will be addressed in subsequent year's rulemaking with comment period.

The potential Medicare PFS fee reductions for not successfully e-prescribing in the future are as follows:

- *1.5 percent for 2013 and*
- *2.0 percent for 2014.*

40 – Reporting Period

(Rev. 1, Issued: 06-11-10, Effective/Implementation: 09-13-10)

The reporting period for the eRx Incentive Program is the entire calendar year. For 2009, for example, the reporting period is January 1, 2009 – December 31, 2009.

50 – Form and Manner of Reporting

(Rev. 1, Issued: 06-11-10, Effective/Implementation: 09-13-10)

Prior to the 2010 eRx Incentive Program, participation in the eRx Incentive Program was limited to the submission of quality data codes (QDCs) for the eRx measure through

Medicare's claim processing system. Beginning with the 2010 eRx Incentive Program, EPs may choose to report the eRx measure to CMS using one of the following reporting mechanisms:

- *Claims-based reporting;*
- *Registry-based reporting; or*
- *EHR-based reporting.*

50.1 – Claims-based Reporting Mechanism

(Rev. 1, Issued: 06-11-10, Effective/Implementation: 09-13-10)

Individual EPs (and beginning with the 2010 eRx Incentive Program, group practices) who choose to participate in the eRx Incentive Program via the claims-based reporting mechanism do not have to enroll or register to begin claims-based reporting of the eRx measure to CMS.

Participating EPs (or group practices) who bill for the services or procedures included in the denominator of the eRx measure report the corresponding appropriate numerator G-code on their claim. Claims-based reporting may be via: (1) the paper-based CMS 1500 Claim form or (2) the equivalent electronic transaction claim, the 837-P. The specifications for the eRx measure are available on the eRx Measure section page of the CMS eRx Incentive Program website at http://www.cms.gov/ERXincentive.

The applicable G-code quality data must be reported on the same claim as the billable service or procedure to which the QDC applies. The eRx measure does not require a specific diagnosis to help determine the denominator; therefore, any diagnosis reported on the claim is sufficient. The analysis algorithms that are used to determine whether an EP is a "successful electronic prescriber" match the QDCs to the service and/or procedure codes on the claim. Thus, QDCs that are not submitted on the same claim as the applicable service and/or procedure codes do not count toward an EP meeting the requirements of being a "successful electronic prescriber."

50.1.1 - Coding and Reporting Principles for Claims-based Reporting

(Rev. 1, Issued: 06-11-10, Effective/Implementation: 09-13-10)

The following principles apply for claims-based reporting of the eRx measure:

- *For the 2009 eRx Incentive Program, report one of the three eRx codes listed below as the claim numerator, when applicable:*
  - *G8443 - "All prescriptions created during the encounter were generated using a qualified eRx system."*
  - *G8445 - "No prescriptions were generated during the encounter."*

- *G8446 - "Provider does have access to a qualified eRx system and some or all of the prescriptions generated during the encounter were printed or phoned in as required by the State or Federal Law or regulations, patient request or pharmacy system being unable to receive electronic transmission; or because they were for narcotics or other controlled substances."*

One of these codes must be reported on at least 50% of patients who meet the denominator criteria of the measure.

- *For 2010 the eRx measure's numerator includes only 1 G-code (CMS eliminated the 3 numerator G-codes used for 2009). To report the eRx measure for 2010, report the following eRx numerator G-code, when applicable:*

  - *G8553 – At least one prescription created during the encounter was generated and transmitted electronically using a qualified eRx system.*

The eRx G-code, which supplies the numerator, must be reported for 25 unique visits (for services in the denominator) to satisfactorily report:

  - *on the same claims as the denominator billing code(s) for the same date of service (DOS)*

  - *for the same beneficiary*

  - *for the same date of service (DOS)*

  - *by the same EP (individual NPI) who performed the covered service as the payment codes, CPT Category I or HCPCS codes, which supply the denominator.*

- *The eRx G-code must be submitted with a line-item charge of zero dollars ($0.00) at the time the associated covered service is performed:*

  - *The submitted charge field cannot be blank.*

  - *The line item charge should be $0.00.*

  - *If an EP's illing software does not allow a $0.00 line-item charge, a nominal amount can be substituted - the beneficiary is not liable for this nominal amount.*

  - *Entire claims with a zero charge will be rejected. (Total charge for the claim cannot be $0.00.)*

  - *Whether a $0.00 charge or a nominal amount is submitted to the carrier/ MAC, the eRx G-code line is denied and tracked.*

- *eRx line items will be denied for payment, but are passed through the claims processing system to the NCH database and used for eRx claims analysis. EPs will receive a Remittance Advice (RA) which includes a standard remark code (N365). N365 reads: "This procedure code is not payable. It is for reporting/information purposes only." The N365 remark code does **NOT** indicate whether the eRx G-code is accurate for that claim or for the measure the EP is attempting to report. N365 only indicates that the eRx G-code passed into NCH.*

- *When a group bills, the group NPI is submitted at the claim level, therefore, the individual rendering/performing physician's NPI must be placed on each line item, including all allowed charges and quality-data line items.*

- *Solo practitioners should follow their normal billing practice of placing their individual NPI in the billing provider field, (#33a on the CMS-1500 form or the electronic equivalent).*

- *Claims may **NOT** be resubmitted for the sole purpose of adding or correcting an eRx code.*

Submission Through Carriers/MACs
eRx G-codes shall be submitted to carriers/MACs either through:

Electronic submission using the ASC X 12N Health Care Claim Transaction (Version 4010A1), or via paper-based submission, using the CMS-1500 claim form.

- ***Electronic Submission:***

*The eRx G-codes should be submitted in the **SV101-2** "Product/Service ID" Data Element on the **SV1** "Professional Service" Segment of the **2400 "Service Line" Loop**.*

- *It is also necessary to identify in this segment that a HCPCS code is being supplied by submitting the HC in data element SV101-1 within the SV1 "Professional Service" Segment.*

- *Diagnosis codes are submitted at the claim level, **Loop 2300, in data element HI01**, and if there are multiple diagnosis codes, in **HI02 through HI08** as needed with a single reference number in the diagnosis pointer.*

- *In general for group billing, report the NPI for the rendering provider in **Loop 2310B** (Rendering Provider Name, claim level) or **2420A** (Rendering Provider Name, line level), using data element **NM109 (NM108=XX)**.*

- ***Paper-based Submission:***

  Paper-based submissions are accomplished using the CMS-1500 claim form (version 08-05). Relevant ICD-9-CM diagnosis codes are entered in Field 21. Service codes (including CPT, HCPCS, CPT Category II and/or G-codes) with any associated modifiers are entered in ***Field 24D*** *with a single reference number in the diagnosis pointer* ***Field 24E*** *that corresponds with the diagnosis number in Field 21.*

- *For group billing, the NPI of the rendering/performing provider is entered in* ***Field 24J*** *and the TIN of the employer is entered in* ***Field 25****.*

Timeliness of Quality Data Submission

Claims processed by the Carrier/MAC must reach the National Claims History (NCH) file by no later than 2 months after the end of the reporting period to be included in the analysis. For the 2010 eRx Incentive Program, for example, claims processed by the Carrier/MAC must reach the NCH file by no later than February 28, 2011 to be included in the analysis. Claims for services furnished toward the end of the reporting period should be filed promptly. Claims that are resubmitted only to add QDCs will not be included in the analysis.

50.2 – Registry-based Reporting Mechanism
(Rev. 1, Issued: 06-11-10, Effective/Implementation: 09-13-10)

Individual EPs (and beginning with the 2010 eRx Incentive Program, group practices) may choose to participate in the eRx Incentive Program via the registry-based reporting mechanism beginning with the 2010 eRx Incentive Program. EPs and group practices that choose to participate in the eRx Incentive Program via the registry-based reporting mechanism do not have to enroll or register to begin registry-based reporting of the eRx measure to CMS. However, to report eRx measure data via the registry-based reporting mechanism, an EP or group practice must select a qualified clinical data registry and must enter into and maintain an appropriate legal arrangement with a qualified clinical data registry. Such arrangements should provide for the registry's receipt of patient-specific data from the EP and the registry's disclosure of eRx measure results and numerator and denominator data on behalf of the EP or group practice to CMS. An EP or group practice choosing the registry-based reporting mechanism must submit information on the eRx measure to their selected registry in the form and manner and by the deadline specified by the registry. Thus the registry would act as a Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104-191) (HIPAA) Business Associate and agent of the eligible professional. Such agents are referred to as "data submission vendors." The "data submission vendors" would have the requisite legal authority to provide information on eRx measure results and numerator and denominator data on the eRx measure on behalf of the eligible professional for the eRx.

Only a registry that is qualified to submit PQRI quality measures information to CMS on behalf of EPs is eligible to become a qualified registry for the purpose of submitting eRx

measure information to CMS on behalf of EPs or group practices. CMS qualifies registries for PQRI for each program year through a self-nomination process (see Chapter 1, §50.2). The list of qualified registries for a specific program year are made available on the CMS eRx Incentive Program website at http://www.cms.gov/ERXincentive. For a specific program year, this list usually is made available in the summer of that same year. For example, we anticipate the list of qualified registries for the 2010 eRx Incentive Program would be made available in the summer of 2010.

50.3 – Electronic Health Record-based (EHR-based) Reporting Mechanism

(Rev. 1, Issued: 06-11-10, Effective/Implementation: 09-13-10)

Individual EPs and group practices may choose to participate in the eRx Incentive Program via the EHR-based reporting mechanism beginning with the 2010 eRx Incentive Program. EPs and group practices that choose to participate in the eRx Incentive Program via the EHR-based reporting mechanism do not have to enroll or register to begin EHR-based reporting of the eRx measure to CMS. However, to report eRx measure data via the EHR-based reporting mechanism, an EP or group practice must select a qualified EHR product. An EP or group practice choosing the EHR-based reporting mechanism must:

- *Have an active Individuals Authorized Access to CMS Systems (IACS) user account that will be used to submit the eRx measure data extracted from the EHR to CMS;*

- *Submit a test file containing real or dummy clinical quality data extracted from the EHR to a CMS clinical data warehouse; and*

- *Submit a file containing the EP's or group practice's eRx measure data extracted from the EHR for the entire reporting period via IACS by no later than 2 months after the end of the reporting period. (For the 2010 reporting period the submission period will be 02/0/11 – 03/31/11)*

Only an EHR product that is qualified for use by EPs to submit PQRI quality measures information to CMS is eligible to become a qualified EHR product for the purpose of an EP or group practice using the product to submit eRx measure information to CMS. CMS qualifies EHR vendors and their specific product(s) for use by EPs to submit PQRI quality measures data to CMS (see Chapter 1, §50.3). The list of qualified EHR vendors and products for a specific program year are made available on the CMS eRx Incentive Program website at http://www.cms.gov/ERXincentive. A list of 2010 qualified EHR vendors and their products are currently posted on the CMS website.

60 – Criteria for Determination of Successful Electronic Prescriber

(Rev. 1, Issued: 06-11-10, Effective/Implementation: 09-13-10)

In order to qualify to earn an eRx incentive payment for a particular program year, EPs and group practices must be considered a "successful electronic prescriber." The criteria that will be used to determine whether an EP or group practice is a successful electronic prescriber differ depending on whether participation is at the individual EP level or at the group practice level and may differ from one program year to another.

60.1 – Criteria for Determination of Successful Electronic Prescriber for Individual Eligible Professionals

(Rev. 1, Issued: 06-11-10, Effective/Implementation: 09-13-10)

For purposes of qualifying for the eRx incentive payment for the 2009 program year, an individual EP was considered a "successful electronic prescriber" if he/she reported the eRx measure (as specified for 2009) on at least 50% of the cases in which the measure is reportable by the EP during the 2009 reporting period.

For purposes of qualifying for the eRx incentive payment for the 2010 program year, an individual EP is considered a "successful electronic prescriber" if he/she reports the eRx measure (as specified for 2010) for at least 25 unique denominator-eligible events during the 2010 reporting period.

60.2 – Criteria for Determination of Successful Electronic Prescriber for Group Practices

(Rev. 1, Issued: 06-11-10, Effective/Implementation: 09-13-10)

For purposes of qualifying for the eRx incentive payment for the 2010 program year, a group practice selected to participate in the eRx GPRO is considered a "successful electronic prescriber" if the practice reports the eRx measure (as specified for 2010) for at least 2,500 unique denominator-eligible events during the 2010 reporting period.

70 – Confidential Feedback Reports

(Rev. 1, Issued: 06-11-10, Effective/Implementation: 09-13-10)

CMS provides confidential feedback reports to participating EPs for a particular program year at or near the time that the lump sum incentive payments are made for the program year. For example, EPs who participate in the 2009 eRx Incentive Program can expect to receive confidential feedback reports with respect to the 2009 program year after the 2009 incentive payments are made in 2010. Access to confidential feedback reports may require EPs to complete an identity-verification process. Receipt of a report is not a requirement for participation in the eRx Incentive Program or to receive an incentive payment.

To receive a feedback report the EP must have had at least one valid eRx measure submission. A valid submission is defined as receipt by CMS of the correct numerator, denominator, age and gender (where applicable) as listed in the eRx measure specifications. The eRx measure specifications are subject to change for each program year. The eRx measure specifications for the current or an upcoming program year, as

well as those for prior program years are posted or archived on the appropriate eRx Program page of the CMS eRx Incentive Program website at http://www.cms.gov/ERXincentive.

In addition, section 1848(m)(5)(G) of the Act requires CMS to post on the CMS website, in an easily understandable format, a list of the names of the EPs (or group practices) who are successful electronic prescribers. Therefore, beginning with the 2009 eRx Incentive Program the names of EPs (and beginning with the 2010 eRx Incentive Program, group practices) who are determined to be successful electronic prescribers for the eRx Incentive Program are required to be posted on http://www.medicare.gov. The names of EPs (and group practices) who are successful electronic prescribers for a particular year will be publicly posted after the lump sum incentive payments for that program year are made in the following year.

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
R1QRI	06/11/2010	Physician Quality Reporting Initiative (PQRI) and E-Prescribing (eRx) Medicare Quality Reporting Incentive Programs Manual	09/13/2010	6935